nature and patient destination. Changes implemented included ensuring the management and follow-up of otitis externa patients met the American Academy of Otolaryngology-Head and Neck Surgery Foundation guidelines. Data for the second cycle was then collected retrospectively over 2 weeks after staff education. A GP letter was issued for every patient seen.
Results: First cycle: 261 patients. Follow-ups: 28%. Reviewed patients: 23% booked for emergency clinic follow-up, 17% booked for main clinic follow-up. Discharge rate: 43%.
Second cycle: 158 patients. Follow-ups: 9%. Reviewed patients: 9% booked for emergency clinic follow-up, 3% booked for main clinic follow-up. Discharge rate: 72%.
Conclusions: Managing the common condition otitis externa according to international guidelines has improved the workload and follow-up rate in the RNTNE emergency clinic. Improving staff numbers has also helped. By setting up correspondence we have also improved communication with GPs.

0563: AN AUDIT OF THE PUNCTUALITY OF THEATRE LISTS WITHIN AN ENT DEPARTMENT

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Aim: Operating theatres utilise between £1-16 million per annum in each trust, with our department's patient waiting lists for elective ENT operations averaging at two months. Our audit aims to assess if our department is maximising our allocated theatre time with punctual starts (standard = 95%).
Methods: A retrospective audit of 35 consecutive, elective theatre lists in a two month period (01.11.2011 – 31.12.2011). We compare start and end times of theatre lists as recorded by the ORMIS theatre system with the scheduled theatre time.
Results: 97% of our theatre lists started late (range10-58 minutes). Of the theatre lists which started late, 74% finished late (range 19-126 minutes), 26% finished early (range 19-126 minutes). 3% of theatre lists started early (9 minutes) and finished late (101 minutes).
Conclusion: We have highlighted an inefficient use of allocated theatre time and propose a supplementary documenting system of theatre timings. This aims to document and raise awareness of which arm(s) of the surgical process (the anaesthetist, theatre staff, surgeon, ward staff or patient) is accountable for the delays. Information from this new system aims to facilitate awareness and further changes.

0579: CONSENT FOR ENT SURGERY - ARE WE THE ONES AT RISK?

Matthew Smith, Raj Lakhani. *Peterborough City Hospital, Peterborough, UK*

Aim: To audit the consent process for common ENT operations against DoH, GMC, RCS and BMA guidance.
Method: Consecutive patients undergoing common ENT procedures were identified. 120 consent forms and all clinic letters relating to tonsillectomy, grommet insertion, septoplasty and hemithyroidectomy were analyzed.
Results: All patients had consent forms. Only 'procedure', 'intended benefit' and 'anaesthetic' sections received 100% completion. Consent was taken by SHOs (4%), Staff grades (14%), SpRs (44%) and Consultants (38%). Day-of-surgery consent occurred in 7.5% cases. The average period between consent and surgery was two months, though consent confirmation only occurred in 40%, with no correlation to period elapsed. The number of risks listed for each procedure decreased with staff seniority. Despite 100% of forms for tonsillectomy listing bleeding as a risk, possible transfusion was only indicated on 20%. Clinic letters rarely featured consent details.
Conclusions: Completion of consent forms is variable. There is poor compliance with guidance from professional bodies. The medico-legal implications are potentially significant and key areas require attention if patient safety and autonomy are to be maintained. Particular focus must be made regarding consent confirmation, consent for blood transfusion in procedures with a significant transfusion rate, and in the listing of operative risks.

0582: CAN WE SLEEP EASY? - AN ASSESSMENT OF OUT-OF-HOURS ENT COVER

Matthew Smith, Raj Lakhani. *Peterborough City Hospital, Peterborough, UK*

Aims: To assess the management of ENT emergencies by 'cross-specialty' SHO's covering ENT at night. To evaluate confidence and experience of 'cross-specialty' SHOs.
Method: An online questionnaire (33 written and photographic true-false questions) was designed to test the management of ENT emergencies. Questions were graded 'essential' or 'desirable' knowledge. A cohort of 'non-ENT' SHO's covering multiple specialties, including ENT, at night (February-November 2011) completed the survey. Additional questions surveyed training, experience and confidence.
Results: 15/18 completed questionnaires were received. The median score was 19/33 (range 15-28/33). Questions testing 'essential' knowledge were answered correctly more often (median score 13/18). Two thirds of SHOs managed 'time-critical' presentations incorrectly, delaying essential treatment. Up to 9/15 mis-managed certain life-threatening conditions. Awareness of postoperative complications was poor. Only 2/15 SHO's had prior ENT experience, 9/15 had no formal training in ENT emergencies and only 7/15 were confident performing an ENT examination. 10/15 self-rated their ENT knowledge as average and 5/15 as poor.
Conclusions: SHOs that cross-cover ENT at night frequently lack relevant training, experience, and essential knowledge required to provide emergency cover for this surgical specialty. In the setting of limited undergraduate education, additional specialist training is required to ensure patient safety.

0594: CLINICAL APPLICABILITY OF THE THY3 SUB-CLASSIFICATION SYSTEM

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Aim: To determine malignancy rates of Thy3a and Thy3f. To assess the clinical applicability of the Thy3 sub-classification system.
Method: A multi-institutional prospective audit of clinical practice, spanning 3 cancer networks in North West London. One hundred and fifteen consecutive patients with Thy3 cytology discussed at the weekly multi-disciplinary team (MDT) meetings between 2010 and 2011 were included. Our main outcome measures were Thy3f and Thy3a malignancy rates, clinical applicability of the Thy3 sub-classification system.
Results: In the present series, 115 Thy3 lesions were identified comprising 83 Thy3f and 32 Thy3a. 65 Thy3f and 11 Thy3a have corresponding histology. 45% of the Thy3f and 64% of Thy3a lesions were found to be malignant on histopathological examination.
Conclusions: The sub-classification has not demonstrated a convincing difference in malignancy rates to help make a translational difference in how we manage these subgroup patients clinically. We have identified Thy3a may have a higher malignancy potential than Thy3f; this may impact on how we evaluate future managements of Thy3a patients.

0597: 'ONE ON, ONE OFF'. A MODEL FOR SAFE AND EFFICIENT PAEDIATRIC ENT SURGERY

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Aims: To demonstrate a system for efficient theatre session management using a 'One on, One off' approach to achieve up to 10 cases per session, and to outline the business case to support it.
Methods: Routine paediatric otolaryngology procedures are allocated for surgery on a dedicated paediatric list. The day surgery ward is transformed to 'Paediatrics Only' and staffed by paediatric nurses. Two paediatric trained Anaesthetists and two Operating Department Assistants (ODAs) are assigned to the list, to allow a 'One On, One Off' system i.e. the next patient anaesthetised by the time the previous case leaves theatre.
Results: Over a two year period, the average number of cases for a single theatre session was 7.9 (range 3-10), compared to 4 on an equivalent session at a neighbouring hospital. The cost of the extra Anaesthetist and ODA was £300, however this additional activity generates extra revenue of £2000-4000, depending on case mix. There were no adverse outcomes during this time period.
Conclusions: This model, easily applied to other surgical specialities, can drive down waiting lists, increase efficiency and improve revenue. The business case for supplying extra Anaesthetic staff is clear and provides fast turnaround whilst maintaining patient safety and training.